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Dying to Get Out: A Study on the Necessity, Importance, and Effectiveness of Prison Early Release Programs for Elderly Inmates and Inmates Suffering from HIV Disease and Other Terminal-Centered Illnesses

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I. INTRODUCTION

"The judge didn't give me a death sentence," she said.[1] Surely, these words came from her soul. Sherri is young, only twenty-eight years old, and is dying from the viciousness of AIDS. Sherri is in the terminal stages of the disease and will live only about six more months. Currently, she sits in solitary confinement, in a medical cell within a men's prison. She is there because the medical treatment facility in the women's correctional center is inadequate to provide the intensive medical care she presently needs. Sherri was a prostitute and is now serving a six-year sentence for her crime. She will probably die before her sentence is completed. Moreover, the effects of Sherri's situation on the Nevada prison system is further compounded by the fact that "the costs of the anti-AIDS drug AZT for inmates is escalating."[2]

Sherri is one of approximately 50,000 incarcerated women in the United States.[3] Sherri quietly spoke, "I don't want to die in prison."[4] Each teardrop sliding down her cheek gave little emotional release to the agony from her physical and emotional death sentence.

"Crime is a young man's game. The sociologists say that all you have to do to cure crime is let them turn 40."[5] A.C.

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1. Interview with Sherri Foulkrod, Inmate, Nevada Women's Correctional Center, in Carson City, Nev. (Nov. 23, 1993) [hereinafter Foulkrod Interview].

2. Robert F. Drinian, *Crime Bill One More Step Into Heart of Darkness; U.S. Omnibus Crime Bill of 1994*, 30 NAT'L CATH. REP. 14 (1994).

3. *Id.* "The incidents of AIDS among woman prisoners is higher than among male inmates." *Id.*

4. Foulkrod Interview, *supra* note 1.

5. Sam Negri, *"Scandal" of Aging Convicts*, ARIZ. REPUBLIC, June 10, 1990,

Bowman knows this to be true. At age fifty, A.C. is serving a fifty-eight-year prison sentence for writing $16,500 in bad checks.[6] He has already lost one kidney to infection, and the prognosis for the remaining one is poor.[7]

A.C.'s medical care costs the Louisiana taxpayers $69,000 a year,[8] which is three times the medical cost for a young prisoner.[9] Ironically, A.C.'s doctors stated that his health insurance would pay the entire cost of his treatment if he were released.[10]

Prisoners like Sherri and A.C. compound the problems of prison overcrowding and cause both medical and incarceration costs to rocket into ever higher orbits. These prisoners who are either elderly or who suffer from terminal illnesses pose only minimal threats to society. State and federal governments must direct their efforts toward prison reform that considers alternatives to incarceration for these types of prisoners, while maintaining public safety.

This paper will focus on aspects of prison overcrowding which are attributable to the incarceration of both elderly and terminally ill inmates. Part II of this paper examines the prison overcrowding dilemma in general and the associated cost problems.[11] Part III discusses the moral impact of keeping elderly or terminally ill inmates incarcerated when they pose little or no threat of harm to the public. Part IV addresses factors specific to older inmates that may affect their early release from incarceration. Part V presents alternative solutions to incarceration for elderly inmates and includes a description of a Project for Older Prisoners (POPS), a program that makes recommendations on the release of elderly inmates and which has recently been used by several states to reduce their inmate populations. Part VI examines the similar challenges posed to the criminal justice system by inmates suffering from terminal illnesses, particularly AIDS, and

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at A1 (quoting Donna Hamm, Director, Middle Ground (A prison reform group), Tempe, Ariz.).

6. Jonathan Eig, *Bill Would Parole Ailing Inmates*, NEW ORLEANS TIMES-PICAYUNE, May 21, 1990, at A1.

7. *Id.*

8. *Id.*

9. Jonathan Turley, *Solving Prison Overcrowding*, N.Y. TIMES, Oct. 9, 1989, at A17 [hereinafter *Solving Prison Overcrowding*].

10. Eig, *supra* note 6, at A4.

11. The voluminous statistics involved in this study will be interspersed as appropriate and necessary within the various sections of this paper.

discusses alternatives to their incarceration. Because elderly inmates and inmates suffering from AIDS have analogous physical ailments and symptoms and pose similar prison cost challenges, the comparison and evaluation of these two groups lead to similar problem resolutions. Part VII presents information on plans and innovative measures proposed as possible solutions to prison overcrowding, with an emphasis on elderly and terminally ill inmates. Part VIII forcefully concludes that our nation must solve the problem of prison overcrowding through expeditiously applied imaginative and effective programs. Although the alternatives suggested are not intended to limit the scope of possible solutions to prison overcrowding, they provide a solid framework from which each state can create an individualized program that will improve the current problems faced by both society and inmates.

II. THE NATIONAL CRISIS OF PRISON OVERCROWDING

"America [is] the world's No. 1 jailer!"[12] The nation's inmate population is almost 1.4 million.[13] The U.S. incarceration rate has risen to 455 per 100,000 citizens.[14] The growth in the U.S. prison population at federal and state levels is astonishing. "Lock'em-up fever" sweeps our news programs and judicial and political arenas as a result of our battle with crime, especially violent crime.[15] The emerging national crisis of prison overcrowding and escalating medical costs for prisoners in our federal and state prisons adversely affects people like Sherri and A.C. Most significantly, the crisis affects the American public's pocketbook.

A. Correctional Statistics on Age and Gender of Inmates

What are the characteristics of a typical prison population in the United States? The number of federal and state inmates, now a population of over 925,000, doubled during the last decade;[16] approximately forty-seven percent of all inmates in

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12. Jill Smolowe, . . . *And Throw Away the Key*, TIME, Feb. 7, 1994, at 55.
13. *Id.*
14. *Id.*
15. Drinian, *supra* note 2, at 14; *see also* Christopher Johns, *Graying of America's Prisons*, ARIZ. REPUBLIC, Oct. 2, 1994, at C3.
16. Smolowe, *supra* note 12, at 58.

state prisons are incarcerated for violent crimes.[17] Most of these inmates are relatively young, although there is evidence of change to an older group. The U.S. Bureau of Justice's statistics on inmates incarcerated in state and federal correctional facilities show that 72.4% of inmates are between the ages of eighteen and thirty-four years old.[18] However, "[t]he nation's prisons are projected to have about 125,000 elderly prisoners by 2001."[19] Moreover, "the Census Bureau reports that by the year 2010 persons over the age of 55 will constitute 20 percent of the U.S. population. By the year 2030, they will compose nearly one third of the U.S. population."[20] People eighty-five years of age and older are the fastest growing population in the country; this group's population will explode by the end of the decade.[21] The increase in elderly inmates should distinctly change the public's perception of the prison population and will contribute to vastly increased medical costs to both federal and state governments.

B. Incarceration Costs and Court Responses to Overcrowding

Americans pay an annual prison tab of $21 billion, with a rapidly growing amount designated for prison construction and care of inmates.[22] Yet, this amount does not include costs for medical care.

The changing characteristics of inmate populations in our federal and state correctional facilities cannot be ignored, and the national challenges they impose cannot be easily solved by the naive "knee-jerk" responses of building new prisons and hiring more security personnel, or by assumptions that "Uncle Sam" and state governments will rescue America from its prison challenges. In fact, many state courts have mandated that states react to overcrowding; "[i]t's no longer a question today of whether or not somebody is going to be released; the question is who."[23]

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17. *Id.*

18. THEODORE M. HAMMETT, U.S. DEP'T OF JUSTICE, SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS 590 (1989).

19. *Law Students Work to Free Elderly, Sick Prison Inmates*, WASH. POST, Jan. 30, 1992, at J5 [hereinafter *Law Students Work to Free*].

20. POPS: PROJECT FOR OLDER PRISONERS, PRELIMINARY REPORT TO THE STATE OF ILLINOIS 24 (1993) [hereinafter POPS].

21. *Shades of Gray* (KUER television broadcast, Feb. 8, 1994).

22. Smolowe, *supra* note 12, at 55.

23. David Holmstrom, *Using Older Convicts as Safety Valve*, CHRISTIAN SCI.

As of June 30, 1988, thirty-three states and the District of Columbia, representing 220 correctional institutions, were under court order to reduce their prison populations because of overcrowding.[24] By May, 1992, "42 states [were] under court order to relieve overcrowding."[25] "One in seven state correctional facilities continue to operate beyond capacity."[26] Nationally, the revolving door syndrome[27] in most prisons results in ever shorter incarceration time for our younger, more violent criminals. As a result, our nation now faces a dilemma: how to provide for the public safety by incarcerating criminals and still solve the prison overcrowding problem.

The need for an answer to that dilemma is pressing. According to Harry Singletary, Director, Department of Corrections for North Carolina, the average prison stay is only sixteen months because of the state's massive overcrowding.[28] Director Singletary dryly calls himself the 'Secretary of Release.' He might just as well call himself the 'Secretary of Readmission.' Since 1991, some 43,000 convicts who were released early because of overcrowding have been rearrested. That makes for a recidivism rate (the statistical probability of an inmate committing a new offense) of 34%, well in line with the national average of 35%.[29]

III. THE MORAL DILEMMA

A possible solution to the dilemma is to release older and terminally ill inmates from prison. However, that proposed solution causes a moral dilemma of its own. Should all inmates who are old or those inmates who, regardless of age, are terminally ill be automatically released from incarceration? How do we decide which of these inmates would not pose a threat to public safety? How do we balance our nation's concern for public safety with the nation's 200-year history of compassion and care for the weak and helpless? The statistics

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MONITOR, May 11, 1992, at 1 (quoting Jonathan Turley).

24. HAMMETT, *supra* note 18, at 109.

25. Holmstrom, *supra* note 23, at 1.

26. Smolowe, *supra* note 12, at 56.

27. The "revolving door syndrome" is a phenomenon where inmates, after having been released from prison, again commit a crime for which they are returned to prison.

28. Smolowe, *supra* note 12, at 56.

29. *Id.*

of overcrowding in America's prisons require that this issue be addressed and resolved in a manner that ethically balances compassion with public safety.

A. The Medical Moral Challenge

Compassion is a deep feeling for and understanding of the misery and suffering of others and a commitment and desire to promote its alleviation.[30] An argument can and should be made that whenever a federal or state government has a medically infirm inmate under its control, the level of medical treatment provided should be the same that a law-abiding citizen would receive in the local community.[31] However, when the challenge for medical treatment includes enormously expensive treatments such as those involved in heart, bone marrow and kidney transplants, the standard for treatment presents both a medical and moral values problem. Should high-tech treatments be rendered to convicted felons when law-abiding citizens may not be able to afford the procedures? These are the real life situations faced by a prison medical staff in the context of restraints on prison funding and overcrowding. The choices become more difficult to make with the accelerated aging of prison populations and their associated diseases.

In contrast to this view is the notion that anyone who commits a crime against society does not deserve elaborate, highly technical, and expensive medical treatment at federal or state expense. However, "[a] cost-benefit argument on medical care generally won't be persuasive to [a] court in a constitutional case."[32] Perhaps the "buck" argument stops in the courtroom. Each case for sophisticated medical treatment brings its own set of variables that involve the inmate, the doctor, prison policy, and the court system. What compounds

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30. Interview with George Kaiser, M.D., Medical Director, Nevada Department of Prisons, in Carson City, Nev. (Nov. 23, 1993).

31. Dr. George Kaiser, Medical Director of the Nevada Department of Prisons, endorses the opportunity for inmates, especially those with HIV disease, to have access to medical research programs under the auspices of the Federal Drug Administration. He is aware that any treatment for an inmate patient must balance humanitarian concerns, cost savings, and the ability of the prison medical facility to provide proper care. *Id.*

32. Jonathan Turley, Alternative Solutions, Address at the Forum on Issues in Corrections (Dec. 7, 1990), (transcript on file with author) [hereinafter Alternative Solutions].

this medical problem is the prison overcrowding phenomenon, which is a challenge that must be addressed before any firm medical policy can be established to ensure that all inmates receive at least adequate medical treatment. Furthermore, if our medical practices are modified in accordance with President Clinton's proposed national health reforms, in which every American would be guaranteed access to treatment by health professionals,[33] it would logically follow that the criminal justice system would no longer be able to deny or limit medical treatment to inmates on grounds of public expense.

B. Public Safety

Overall, public safety must be the paramount moral concern in considering the release of any inmate who might be elderly, infirm, or terminally ill, especially those suffering from AIDS. In Nevada, for example, a male inmate with AIDS, who was incarcerated at a medium custody facility, was recently granted a pardon from his six-year sentence for drug trafficking.[34] Frank Leserra had served only ten months of his sentence before receiving a pardon based on the testimony of his lawyer and prison doctor that he had less than a year to live.[35] Within one week following his release, the inmate snatched a purse from a patron of a Las Vegas lounge.[36] He was chased by two detectives, who happened to be present during this criminal act.[37] The detectives subdued Mr. Leserra and handcuffed him; within two minutes, Frank Leserra died at the scene.[38] This incident, however, is an exception rather than the norm, at least as it concerns the public safety risk posed by terminally ill inmates released for medical and humanitarian reasons.[39]

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33. President Clinton's original proposal for health care reform called for health insurance coverage of every American. President William J. Clinton, President's State of the Union Address (Jan. 25, 1994).

34. Alonza Robertson, *Recently Freed Man Dies After Struggle*, LAS VEGAS REVIEW-JOURNAL, Dec. 16, 1993, at 1B.

35. *Id.* at 1B, 7B.

36. *Id.* at 1B.

37. *Id.*

38. *Id.*

39. While assigned as the Inmate Release Coordinator at a Nevada prison in 1987, my duties included processing releases for all inmates pardoned by the Nevada Board of Pardons, with releases based primarily on the inmates' terminal illnesses. Only rarely was one of these inmates not severely incapacitated to the

IV. OLDER INMATES

The care required for aging inmates is a growing problem in prisons nationwide. By 1989, there were 20,000 prisoners older than fifty-five and that figure is doubling every four years.[40] In 1989, this growth included more than 400 inmates over the age of eighty-five.[41] Sol Chaneles, a Rutgers University law professor, predicted that "[i]n 20 years . . . we will rename prisons Centers for the Treatment of Old Folks."[42] Statistics from the criminal justice system verify that elderly inmates have the lowest recidivism rate.[43] Yet, as inmates age, their institutional costs skyrocket.

In the political zeal to get tough on crime, evidenced by long sentences and mandated sentences before parole eligibility (for example, predetermined terms for drug offenses and carjacking), our courts and legislators have created the "graying" of the inmate population. These older inmates would be ideal targets for early prison release. Factors unique to older inmates, as discussed in the next section, are relevant to their discharge from incarceration, whether it be by parole, probation, or medical release.

A. Pardons and Paroles for Older Inmates

Despite the overwhelming growth of an elderly prison population, elderly prisoners are not, as a matter of course, granted pardons, commutations or paroles.[44] Yet, older, non-violent inmates are not a priority in prison.[45] These inmates may be serving life sentences, with or without the possibility of parole, for violent offenses committed in their youth. Prisons are more concerned with prisoners who are violent while in prison.[46] These are the prisoners requiring the most secure custody environment and intense supervision.

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extent of confinement to a wheelchair or to total reliance on others for physical assistance. These inmates were close to death and their release to their families seemed to be one of common sense and moral justification.

40. Ginny Carroll, *Growing Old Behind Bars*, NEWSWEEK, Nov. 20, 1989, at 70.

41. *Id.*

42. *Id.*

43. POPS, *supra* note 20, at 7.

44. Carroll, *supra* note 40, at 70.

45. *Solving Prison Overcrowding*, *supra* note 9, at A17.

46. *Id.*

A low recidivism rate for older inmates is one of the strongest rationales for expediting release of elderly prisoners. Allen Beck, a Justice Department statistician, stated that "[a]ge is the strongest factor in the odds of whether a person will be arrested after release . . . . [A]ge is stronger than what a person was arrested for and the number of years spent in jail."[47] Studies verify that older inmates possess the lowest recidivism rates. The U.S. Parole Commission uses age as the most reliable predictor of recidivism, which verifies that inmates over forty-five years old are only 2.1% likely to commit another crime.[48] After age thirty-five, the recidivism rate sharply drops, with inmates in their forties and fifties having the lowest levels.[49] "Assuming that the statistical curve continues for older groups, [a] federal study suggests a possible recidivist rate of 15% for inmates over age 55."[50] In a Project for Older Prisoners study completed for the State of Illinois, the data showed that "[t]he recidivism rate for all [Illinois] inmates is 42% while the recidivism rate for inmates over age 55 is only 17%."[51] Age, then, is a critical factor in predicting the likelihood of recidivism and is relevant in determining which inmates are best qualified for release.

The correctional system is not the only organization which bears the burden of responding to what these recidivism statistics show regarding the older inmate; the legislature does as well. "[T]he Corrections Department says it has no choice but to do what the Legislature and courts tell it to do, which is to accept more inmates, and often for longer periods of time."[52] Legislators must be informed of these statistics and of ways to develop new programs for inmate release in order to alleviate overcrowding.

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47. Tyler Bridges, *Angola Pays Big Tab for Its Elderly Inmates*, NEW ORLEANS TIMES-PICAYUNE, Aug. 20, 1989, at A1.

48. Negri, *supra* note 5, at A1.

49. Matt Neufeld, *Release for Older Inmates Sought*, WASH. TIMES, July 28, 1992, at B3 (paraphrasing Jonathan Turley).

50. POPS, *supra* note 20, at 7.

51. *Id.* at 6.

52. Negri, *supra* note 5, at A1.

B. Skill Levels of Older Inmates

Older inmates may be highly skilled, through trades learned before entering prison or through job training in prison. These inmates can greatly contribute to the smooth functioning of prison administration, benefiting the prison's work product unit.[53] They may possess highly specialized skills important to the prison's physical plant operations.[54] In these instances, prison officials may be reluctant to release them early because of their unique contributions and the low risk of escape or danger to the staff or other inmates.[55] In short, these inmates maintain the status quo.

C. Increased Number of Lawsuits by Older Inmates

The possibility is substantial that prison officials will be bombarded with class action lawsuits by elderly inmates seeking adequate safety, care, and special accommodations for their specific needs. If a prison fails to respond to these requests by elderly inmates, the inmates may argue that such inaction constitutes "cruel and unusual punishment" in violation of Eighth Amendment guarantees.[56] For instance, "[s]tudies have shown that a young offender with a long sentence ahead of him often turns anger into exploitative behavior towards elderly prisoners."[57]

One possible way to protect elderly inmates is to segregate them from the general inmate population, housing them instead in a separate geriatric facility operated by prison officials or private organizations. Overall, this alternative has been successfully used and meets the dual goals of safety for older inmates and more adequate care for their age-related diseases.

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53. This author's experiences and observations as a prison classification counselor at both maximum security and medium custody correctional facilities in Nevada support this.

54. *Id.*

55. *Id.*

56. U.S. CONST. amend. VIII.

57. POPS, *supra* note 20, at 16-17 (quoting Sol Chaneles in *Growing Old Behind Bars: The Aging of Our Convict Population Brings with It Special Needs and Problems that Few of Our Prisons Are Ready to Handle*, PSYCHOL. TODAY, Oct. 1987, at 46).

D. Medical Costs for Older Inmates

Medical costs alone represent a powerful reason for early release of elderly inmates. Annual costs for the care of older inmates are two to three times that of younger prisoners.[58]

Health care is unquestionably one of the major budgetary concerns for prisons nationwide. For instance, in Illinois "[h]ealth care costs for inmates have increased over 100% in the past ten years."[59] Alternative programs, including pardons, medical and compassionate releases, use of the electronic detection device and specialized housing arrangements, have been proposed in Illinois for the older and terminally ill inmates.[60] The viability of these alternatives as solutions to overcrowding and the public's concern over safety will be examined further in Part V.

E. Challenges to Care of Elderly Inmates

The medical facilities in almost all state and federal prisons are simply not equipped with the medical nursing staff and disease specialists to effectively provide the appropriate care necessary to treat elderly inmates.[61] Because of these inadequacies, innovative solutions are required.

1. The prison hospital system and medical treatment of older inmates

The increased number of elderly inmates is positively correlated to the increased costs necessary to care for them adequately:

> The American prison hospital system is collapsing under the pressure of both expanding prison populations and rising health care costs. Ninety percent of the country's 600 prison hospitals do not meet basic standards of care established by the

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58. *Solving Prison Overcrowding*, *supra* note 9, at C19.

59. POPS, *supra* note 20, at 32 (citing B. Jaye Anno, *The Cost of Correctional Health Care: Results of a National Survey*, 1990 NAT'L COMM'N ON CORRECTIONAL HEALTH CARE 7).

60. POPS, *supra* note 20, at 43-50.

61. Jonathan Turley, *Why Prison Health Care Is a Crime*, CHICAGO TRIBUNE, Mar. 19, 1991, at C19 [hereinafter *Why Prison Health Care Is a Crime*].

> medical profession. Prison hospitals are being required to care for inmates in severely overcrowded facilities with staff and resources that would be barely adequate for half the number of prisoners. As a result, inmates are dying from ailments that go unattended or are treated improperly.[62]

Moreover, allowing such illnesses to go unattended may be considered a violation of the Eighth Amendment.[63] In 1976, The United States Supreme Court stated that "[d]eliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain . . . proscribed by the Eighth Amendment."[64]

In addition, the health care challenge represents major budgetary concerns for all federal and state correctional systems. "In 1984, citizens over 65 years old represented 12% of the U.S. population, but 31% of total personal health care expenditures. This contrast is even greater in correctional facilities where older inmates impose two to three times the average cost of younger inmates."[65]

"Experts agree that an inmate's institutional age is much greater than his chronological age because of the stress of prison life. Federal figures indicate that an inmate is on the average 7 to 8 years older in physiological years than in chronological years."[66] This means that "65 years is a standard yardstick for 'geriatric' individuals in the general population, while 50 or 55 is a more common demarcation for the same individuals in inmate populations."[67]

"In the often hostile and highly stressful atmosphere of a correctional facility, where inmates tend to age at a much faster rate than the general population, the percentage of older prisoners having difficulty with personal activities is quite high."[68] Indeed, "[o]lder inmates suffer an average of three chronic illnesses in prison . . . ."[69] Skyrocketing costs in

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62. *Id.*

63. *See also* textual discussion *infra* part IV.C.

64. Estelle v. Gamble, 429 U.S. 97, 104 (1976).

65. POPS, *supra* note 20, at 30 (citing AARP, A PROFILE OF OLDER AMERICANS, 14 n.1 (1988)).

66. POPS, *supra* note 20, at 6.

67. *Id.*

68. *Id.* at 30.

69. Victoria Benning & David Carlton, *Elderly Inmates Pack Prisons; Cause*

treating these age-related illnesses can often be reduced, and in some cases eliminated, by early detection and treatment. If the prison hospital system fails to address these issues, the courts may force recognition and remedial reaction to the problems. Furthermore, courts may award damages to inmates who have not received adequate medical treatment.[70]

Much of this crisis (in prison hospitals) can be eliminated by staffing prison hospitals at their rated levels. Adding prison doctors and nurses can reduce costs for the system as well as improve care for the inmates. Today, many hospitals spend unnecessarily to 'contract out' basic services that could be handled in a fully staffed prison hospital. By expanding the prison hospital staff, a prison also increases the system's ability to detect and treat medical problems before they become expensive, chronic illness. Preventive care is essential to control the costs of a prison population that is graying and becoming more susceptible to geriatric illness.

Even with fully staffed hospitals, however, prison systems will have to make some hard decisions on how to use their dwindling resources in the '90s. Just as military doctors must decide who can be saved on a battlefield, prison systems must make logical decisions as to who we incarcerate, and how, in a system that is chronically overcrowded. A prison triage policy does not mean that cost should replace culpability as a basis of incarceration. Rather, prisons must conserve resources and space for high-risk prisoners by controlling costs on low-risk prisoners.[71]

2. Treatment of geriatric illnesses in prison

Geriatric illnesses within the prison environment are not only treatable but preventable. For instance, ulcer patients might reduce or eliminate symptoms by eating a special diet;[72] cataracts and glaucoma are in large part preventable with proper monitoring and treatment;[73] and heart disease and

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Concern About Cost, Care, GANNETT NEWS SERVICE, May 17, 1990, at 12 (citing Jonathan Turley).

70. Paul F. Mapelli, *AIDS in Prison*, 20 COLUM. HUM. RTS. L. REV. S-19, S-27 (1989).

71. *Why Prison Health Care Is a Crime*, *supra* note 61, at C19.

72. Charlotte Sutton, *U.S. Prisons Are Graying, Meeting Told*, ST. PETERSBURG TIMES, Aug. 14, 1991, at 1B (citing Jonathan Turley).

73. *Project Helps Protect Elderly Missouri Resident*, UNITED PRESS INT'L, Mar.

osteoporosis can be prevented and treated "with proper attention, diet and exercise."[74] Other diseases are simply misdiagnosed. Thyroid disease, for example, includes symptoms (fatigue, diarrhea or constipation, high cholesterol, forgetfulness, muscle pain)[75] that mimic symptoms associated with the common manifestations of old age.

Diagnostic measures cannot be rendered quickly and often require diagnosis by a geriatric specialist. "Thyroid disease is but one of many such ailments with 'cloaked' or confusing symptoms for older patients. Accordingly, geriatric illness is often misdiagnosed or overlooked, resulting in more serious health consequences"[76] and, consequently, vastly increased costs for medical intervention.

The older inmates' deteriorating physical condition is not the only problem that must capture the attention of prison officials. Elderly inmates have social, work, and mental health needs quite different from those of younger prisoners. For example, some inmates suffering from arthritis have difficulty with simple tasks such as fastening their clothing and shoes and need Velcro straps to accomplish such tasks.[77] Some inmates need wheelchairs.[78] Consequently, prisons need ramps for wheelchairs, and doors must be wide enough for the wheelchairs to enter and exit easily. Other inmates need canes, walkers, and various other aids for their mobility.[79] Elderly inmates confined to wheelchairs need more stimulation than staring at a television all day; mental health professionals rarely devote quality time to improving the depression suffered by older inmates.[80] Those with Alzheimer's disease represent yet another group needing individualized care in their daily activities.[81] Usually, treatment of these infirmities are just "catch as catch can."[82] Nevertheless, these medical aspects are

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20, 1990.

74. POPS, *supra* note 20, at 19.

75. Don Colburn, *Thyroid: What Happens When the Gland Goes Awry*, WASH. POST, May 21, 1991, at Z10; *see also*, Lawrence K. Altman, *Researchers Finding New Ways to Learn About Graves' Disease*, N.Y. TIMES, July 23, 1991, at C3.

76. POPS, *supra* note 20, at 19.

77. *See* Carroll, *supra* note 40, at 70.

78. Chris Black, *Aging Behind Bars: Effects of the Graying of America's Prisons*, B. GLOBE, June 12, 1989, at 3.

79. *Id.*

80. POPS, *supra* note 20, at 19.

81. *Id.*

82. *Id.*

becoming crucial in prison systems where there is escalating growth in the number of elderly inmates.

V. ALTERNATIVES TO PRISON CONFINEMENT OF ELDERLY INMATES

Medical costs for the treatment of elderly inmates are enormous. Other alternatives must be developed and instituted if we are ever to resolve the problem of prison overcrowding.

A. Benefits of Prison-Managed Geriatric Institutions

A large share of geriatric costs can be reduced and even reclaimed through decreases in fixed security costs. "Personnel [costs] will often amount to nearly fifty percent of the operating costs of a correctional facility."[83] A marked decrease in these costs, however, can be realized by assigning some inmates to specialized geriatric units. Inmates suitable for reassignment to such institutions would include the non-violent, who comprise the vast majority of elderly prisoners, and other older or terminally ill prisoners. These geriatric units may be located in segregated wings of prison housing, in under-utilized hospital facilities, or in hospitals located on military bases listed for government closure. An added benefit to this proposed housing structure is the freeing of cells in the main part of the prison for the more dangerous, and usually younger, inmates.[84]

A model for such a specialized facility exists at the McCain Correctional Hospital in McCain, North Carolina. The approximately 350-bed facility was converted from a tuberculosis hospital into a correctional hospital.[85] Placing older inmates in a facility such as McCain serves several purposes: (1) protection of elderly inmates from victimization by younger prisoners; (2) reduction in security costs; (3) concentration of a multi-discipline health care plan targeted for the elderly; (4) establishment of open cells in medium and maximum security units for use by higher risk, younger inmates; and (5) creation of an environment wherein inmates may socially interact more appropriately and possibly improve both physically and emotionally.

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83. *Id.* at 17.
84. *Id.* at 18.
85. *Id.*

"[A]t McCain, the Department of Corrections has been able to reduce costs, but its older inmates still cost twice that of its younger inmates."[86] The security cost savings at McCain were achieved because of a significant reduction in the number of required security personnel.[87] "This reduced staffing is a result of the fact that while an older inmate may be a risk for recidivism for rape or molestation, due to old age or infirmity, the inmate likely presents a low risk for escape or violence."[88] Donald Newman, a sociologist with the State University of New York at Albany, commented that "[n]o matter what the elderly criminals did, they don't need handcuffs, leg irons and a 30-foot wall . . . ."[89]

The author has personal experience as a counselor in both maximum and medium prison facilities, and adds that older inmates also do not require razor wire, "stun" guns, or firearms to keep them confined or to control their behavior. By placing them in a correctional nursing environment designed specifically for elderly inmates, they may and should improve. In this concentration of medical and social efforts to meet their special needs, the inmates may surprise the medical profession and improve enough to transfer to a regular nursing home, merit compassionate releases during which they can care for themselves, and may even be paroled to the community and integrate successfully into society.

Consider the case of Quenton Brown, a cherry pie thief.[90] Through the legal efforts of a law professor and Brown's own exemplary prison record, he was released, after serving eighteen years of a thirty-year sentence.[91] At the age of seventy, Quenton is now employed as a baker—making pies.[92] We should not underestimate the abilities of our elderly prisoners when they are in good health. After all, Brown only had an I.Q. of fifty-one[93] and had been imprisoned for nearly two decades, but he is now a law-abiding and tax-paying citizen.

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86. *Id.*
87. *Id.*
88. *Id.*
89. Carroll, *supra* note 40, at 70.
90. *See infra* part V.D.
91. Holmstrom, *supra* note 23, at 1.
92. Alternative Solutions, *supra* note 32, at 50, 52.
93. *Id.* at 50.

B. Benefits of the Electronic Home Detention Program

Another possible solution to prison overcrowding is electronic home detention programs. An average of $65 a day is spent by most states on the housing costs for one inmate.[94] The use of electronic detention devices (ED), commonly called electronic "bracelets," can reduce this daily cost by $57.[95] The State of Illinois, based on its Electronic Home Detention Law, implemented an electronic home detention program beginning July 1, 1989.[96] Over 5,000 offenders have been monitored by the program.[97] Of this group, sixty-six percent successfully completed the program, while twenty-four percent failed the program.[98]

The ED program has been determined to be cost-efficient in Illinois and other states.[99] Additionally, Illinois has refined its program to decrease the daily costs, and rarely are inmates monitored by the bracelet for longer than nine months.[100] Electronic detention is an effective alternative to incarceration because (1) technical improvements have reduced the amount of human control needed; (2) equipment costs are lowered; and (3) an escalating number of inmates are participating.[101] Furthermore, inmates who are capable of working must obtain employment and pay a percentage of their earnings to reimburse the state for their housing costs.[102]

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94. Jonathan Turley, *Our Prison Profiteers*, N.Y. TIMES, Aug. 3, 1990, at A27.

95. *Id.*

96. ILL. ANN. STAT. ch. 730, para. 5/5-8A-1 (Smith-Hurd 1994) (The Illinois Electronic Home Detention Law currently excludes any person charged with or convicted of first degree murder, escape, or a Class X or Class 1 felony); *see also*, POPS, *supra* note 20, at 22, 26.

97. *See* POPS, *supra* note 20, at 22.

98. *Id.* Causes for failure include, among other things: leaving the home premises without permission; attempting to remove equipment; and failing to comply with work release program rules. However, the causes do not include committing crimes or using controlled substances. A total of 9.5% were returned to prison for administrative reasons. *Id.*

99. *Id.* at 23. Annual costs for the use of ED in Illinois have steadily decreased from over $7,400 in fiscal year 1990 to about $5,800 in fiscal year 1992. *Id.*

100. *Id.*

101. *Id.*

102. *Id.* Refinements in the design and manufacture of electronic detection devices make them much more acceptable to inmates than the early versions. Initially, parolees and probationers selected for the ED system found the bracelet bulky and uncomfortable. Normally worn on the ankle of the released felon, the bracelet is now significantly more comfortable while still effective for short term

Unfortunately, Illinois release criteria "do not account for the physiological effects of age on recidivist behavior."[103] As a result, older inmates in the final months or years of incarceration will not even be eligible for ED if they committed one of the serious felonies identified by the statute. Nevertheless, the low risk posed by elderly inmates identifies them as excellent candidates for electronic detention.

The phenomenon occurring with the use of ED could cause a conceptual shift in the correctional system and the courts. The ED device is beginning to be viewed as an alternative form of incarceration for special category offenders instead of a transition program from custody. For states that are under court order to reduce overcrowding, application of the ED program may be an attractive alternative to incarceration. For example, "by June of 1994, the Illinois correctional system will hold 36,000 offenders in a system designed to hold 21,000."[104] If such growth continues, it "will carry the Illinois system beyond federal ceiling capacity and likely force mandatory court release."[105]

Several other states are facing the same overcrowding dilemma as Illinois. In North Carolina, the prisons system has a net gain of 200 inmates per week.[106] Because of a statutory limit on the number of inmates (21,400 incarcerated prisoners), Governor James Hunt, Jr., has proposed that the legislature expedite the openings of two of the state's twelve new prisons under construction, in addition to leasing space in county jails.[107] If Governor Hunt fails to convince the legislature, "he will be forced to release 3,400 inmates."[108] This prison overcrowding scenario is similar to that experienced by most of the fifty states. Application of the ED system to the correctional overcrowding problem, and especially the inclusion of elderly inmates convicted of violent crimes in the selection process, will definitely reduce the prison inmate population immediately.

Because of elderly inmates' low recidivism rates, an ED program could be designed to increase their chances of

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application.

103. *Id.* at 27.
104. *Id.*
105. *Id.*
106. Smolowe, *supra* note 12, at 56.
107. *Id.*
108. *Id.*

selection for parole and medical or compassionate release. They could be committed to their pre-incarceration homes within the individually specified confines of the ED and monitored for a designated time frame.

However, some elderly inmates have lost all ties to their families and remain without housing arrangements. This makes it difficult for them to get parole because the nation's current parole system generally requires an inmate to have definitive housing before his or her release. "[A]bout 50% of ED candidates who pass the statutory requirement and are initially approved for the ED program are ultimately denied participation because they have no place to go for their detention."[109] Group homes for these offenders, especially those who are in good health, are a good resource and would contribute to reduction of prison costs.[110] Halfway houses, managed by the correctional system or private enterprises, can effectively provide temporary residences for released inmates. In these homes, releasees must comply with household duties, residence rules, and seek employment. Under these housing conditions, the elderly inmates could easily be monitored by their electronic bracelets. The costs to a correctional system to maintain group homes "would likely be higher per offender than conventional ED but would still be considerably less than conventional prison incarceration."[111]

Yet the costs to develop, staff, and operate group homes for elderly inmates should not be borne totally by prisons. As previously mentioned, prison reform should require a coordinated state agency effort. Additionally, state funds could finance the group homes (even a converted motel, as is done in Reno, Nevada's minimum security Community Restitution Center). The goal for these would be to have low-care nursing staff and a minimum number of security personnel to monitor the inmates in the ED program. "In the case of both group homes and low-care nursing homes, placement could be based on a combination of low risk and high need. Such a grouping of older ED offenders with similar needs should facilitate administration and cost control."[112]

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109. POPS, *supra* note 20, at 28.
110. *Id.*
111. *Id.*
112. *Id.*

C. Early Conditional Medical Release/Parole for Terminally Ill Elderly Inmates

A third possible solution to prison overcrowding is to establish the early release of elderly and terminally ill inmates. The demographic trend indicates that one-third of the U.S. prison population will be comprised of elderly inmates by the year 2030.[113] Their health needs cannot be ignored. The imperative medical demands these inmates will make on prison hospitals should necessitate that each state's governor establish an administrative body to review this problem. This committee would recommend to the governor medical releases for inmates designated by the correctional system as elderly and infirm or terminally ill. Alternatively, the committee could aid the parole board and concentrate solely on medical release.

Parole boards are notoriously overworked and cannot spend adequate time on medical release cases in addition to their normal parole board hearings. Therefore, an administrative body selected by the governor to exclusively manage these medical release cases would expedite the time from review to final decision. State savings generated by expediting medical releases is emphasized by the following action in New York:

> Various states have moved to medical release options to better control rising costs. In New York, Governor Mario Cuomo's fiscal plan for 1992 projected a total savings of $478,800 from the release of 120 terminally ill inmates from the New York state system under his proposed medical parole program. Now, after passage of that program, a more recent estimate by Governor Cuomo has placed the public savings at $2 million for the first year.[114]

"Both the Connecticut and the District of Columbia medical release provisions specifically address the issue of speedy decision-making, while in comparison the Maryland Parole Commission grants medical parole through a process that takes up to 30 to 60 days."[115] During that one- to two-month time

113. *Id.* at 24.
114. *Id.* at 31.
115. *Id.* at 32.

frame, terminally ill elderly inmates could die while waiting. The medical release process should be fast, accurate, and thorough. The administrative group selected to manage medical releases should be comprised of professionals in the medical, legal, business, and prison career fields. Positions on the committee should not be filled with political appointees who may fail to meet strict professional standards. This composition would provide a balanced focus on an inmate's proposed release that would not be achieved by assigning the task to a single professional entity.

D. POPS: Project for Older Prisoners

Creative ideas in a public context that actually work when put into practice are rare. Rarer still is an innovative idea that is based upon both moral as well as intellectual foundations. The organization Project for Older Prisoners (POPS) is based upon both of these characteristics and is a fourth possible solution to prison overcrowding.

In 1989, Jonathan Turley taught at Tulane University Law School.[116] Turley agreed to represent a Louisiana inmate, Quenton Brown, who was appealing his conviction for stealing $100 in cash and a fifteen-cent cherry pie from a bread store.[117] Brown was convicted and sentenced to thirty years for his crime.[118] He had been incarcerated for eighteen years.[119]

The 67-year-old Brown had an I.Q. of fifty-one.[120] Eventually, Turley managed to convince both prison officials and the court that Brown only posed a minimal danger to anyone.[121] Further, Turley noted to the court "that the recidivism rate for released prisoners over 45 is only 2 percent."[122] Brown was released.[123]

Turley believed that an early release program for elderly inmates could reduce the prisons' high incarceration costs that are usually necessary to support the elderly, infirm prisoner.

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116. Holmstrom, *supra* note 23, at 1.
117. *Id.*
118. *Id.*
119. *Id.*
120. Alternative Solutions, *supra* note 32, at 50.
121. Holmstrom, *supra* note 23, at 1.
122. *Id.*
123. *Id.*

He saw the need and filled it. Turley saw absolutely no reason to allow a "broken-down old man to die in prison."[124] The idea for POPS was born.

1. Establishment of POPS

Turley's success in Brown's case spread through the prison "grapevine" like wildfire.[125] Many other older inmates contacted him, and Turley represented some of them.[126] Finally in 1989, his idea bore fruit. He enlisted law students to assist him in pro bono work with older inmates.[127] The response from students at Tulane Law School astonished Turley. Turley stated, "I thought I had walked into the wrong room. There were more than 250 students."[128] The student response resulted in the creation of POPS.[129]

After establishing the POPS program at Tulane, Professor Turley organized another POPS program at George Washington (GW) with the help of seventy-five law students.[130] This augmented the efforts of students persevering with the program at Tulane. In the process, POPS developed into "one of the nation's largest volunteer prison assistance projects."[131]

"POPS assisted in passing model prison legislation in Louisiana in 1989. The new POPS office at GW will help Congress, the District of Columbia, Maryland and Virginia with new laws governing incarceration."[132] POPS is not designed as a prisoner advocacy group. Rather, it functions as a public advocate whose "chief objective is to decrease recidivist crime in society by better utilizing . . . available prison cell capacity and resources."[133]

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124. Carroll, *supra* note 40, at 70 (quoting Jonathan Turley).
125. Holmstrom, *supra* note 23, at 1.
126. *Id.*
127. *Id.*
128. *Id.*
129. *Id.*
130. *Law Students Work to Free*, *supra* note 19.
131. *Id.*
132. *Law Students Work for Elderly Inmates in Project for Older Prisoners*, NEWS (Off. of U. Rel., Geo. Wash. U., Wash., D.C.), July 30, 1991, at 3 [hereinafter *Law Students Work for Elderly*].
133. POPS, *supra* note 20, at 9.

2. Functioning of POPS

Initially, POPS identifies low-risk, high-cost prisoners at a particular correctional facility. These inmates are then individually assigned to the law students, who perform extensive background checks on the prisoners and assess social needs.[134] This allows the students to predict recidivism, which must be low enough to qualify for POPS.[135] If the inmate qualifies under the POPS rigid risk assessment, then the student confirms the inmate's proposed living arrangements and, if appropriate, employment plans.[136] The inmate's family is brought into the risk assessment process,[137] as well as the inmate's institutional record and the perspective of the victim or victim's family.[138] Finally, when the entire risk assessment package is completed and approved, POPS presents the inmate's parole/pardon request to the applicable state board.[139] This entire process must also integrate with the particular state's legislative early release mandates.

"Since 1989, more than 500 prisoners have been assisted by POPS with law students working in five states . . . ."[140] The project, supported entirely by students, receives no financial support from outside funding, and in most cases the students pay for all expenses.[141] Unquestionably, these students are a credit to the legal profession.

Professor Turley views POPS as a means of "bringing public interest law into the forefront of legal education."[142] The services of POPS have significantly impacted the release system in several states.[143] The program, which has become more formalized, has been presented to numerous state legislatures by Turley.[144] This can only be viewed as part of a

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134. *Id.* at 11.
135. *Id.* at 12.
136. *Id.* 15-16.
137. *Id.*
138. *Id.* at 11.
139. *Id.* at 16.
140. Kellie Boyet, *The Community of Forgotten Men*, POPS PROGRAM FACTS 14 (1993).
141. Alternative Solutions, *supra* note 32, at 50-51.
142. *Law Students Work for Elderly*, *supra* note 132, at 3.
143. Alternative Solutions, *supra* note 32, at 51 ("POPS has gotten into the business of legislation, and we've been quite successful.").
144. *Law Students Work for Elderly*, *supra* note 132, at 1.

multi-state attempt to develop new policies and laws for the dramatically increased number of geriatric prisoners already filling their prisons and to plan for the projected increases in the number of elderly prisoners expected by the next century.

VI. INMATES SUFFERING FROM AIDS

HIV-positive prisoners and elderly prisoners present analogous challenges to criminal justice systems because they have similar diseases, like heart disease and emphysema.[145] The solutions and alternatives to confinement previously discussed for elderly inmates will also work for inmates with AIDS.

A. Information on Costs of Treating HIV-Related Complex Illnesses in Correctional Institutions

New York's 1990 estimate on the cost of keeping one AIDS patient hospitalized for one month was $22,631.[146]

> More recent figures estimate the per year cost of caring for an inmate infected with AIDS at approximately $38,000. While incarceration in Washington, D.C. costs about $23,300 per year for the average inmate, incarceration of its AIDS victims costs approximately $60,000 per year per inmate. This is strikingly similar to the costs of older prisoners whose special needs can drive annual correctional costs as high as $50,000 to $60,000 per year.[147]

In the District of Columbia, a "non-prisoner with AIDS who uses hospice care rather than a traditional hospital in the last six months of life can save as much as $15,000. The savings for a prisoner with AIDS would be substantially higher because prison health care requires far more labor."[148]

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145. POPS, *supra* note 20, at 31.
146. *Why Delay? Albany's Unfinished Business*, NEWSDAY, June 29, 1990, at 66.
147. POPS, *supra* note 20, at 31.
148. *Id.*

B. HIV Disease in the Correctional System

The 1990 National Institute of Justice (NIJ) report on HIV disease shows that by December, 1990, over 100,000 people had died in the United States from AIDS, with over one-third of those deaths reported in 1990.[149] "AIDS [has] emerged as a leading cause of death among . . . males 25-44 years of age, eclipsing heart disease, cancer, homicide, and suicide."[150] Also, in 1991 The National Commission on AIDS reported on the increasing significance of AIDS in America's prisons:

> HIV disease is a profound presence in the nation's prisons and jails. As the number of AIDS cases grows, correctional facilities are by necessity transformed. . . . According to surveys conducted for the National Institute of Justice (NIJ), through October 1989, there were 5,411 confirmed cases of AIDS reported from the Federal Bureau of Prisons, state prison systems and a sample of 27 to 38 county and city jail systems in the United States. The cumulative number of reported AIDS cases among inmates increased from 766 in November 1985, representing an astounding four year increase of 606%.[151]

The astonishing increases of AIDS in correctional facilities may even be underestimated because of the rapid turnover of prisoners in city and county jails, where AIDS testing might be unavailable (or not used).[152]

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149. THEODORE M. HAMMETT & ANDREA L. DAUGHERTY, U.S. DEP'T OF JUSTICE, 1990 UPDATE: AIDS IN CORRECTIONAL FACILITIES 9 (1991).

150. *Id.*

151. NAT'L COMM'N ON AIDS: REPORT ON HIV DISEASE IN CORRECTIONAL FACILITIES 10 (Mar. 1991) (footnote omitted) [hereinafter HIV DISEASE IN CORRECTIONAL FACILITIES].

152. "Although there may be indications that the HIV epidemic is slowing in prisons and jails, it is still a very serious problem. A recent analysis of inmate mortality in Maryland, for example, revealed that AIDS has been the leading cause of death among male inmates since 1987." HAMMETT & DAUGHERTY, *supra* note 149, at 24 n.16. (quoting M.E. Salive et al., *Death in Prison: Changing Mortality Patterns Among Male Prisoners in Maryland, 1979-1987*, 80 AM. J. OF PUB. HEALTH 1479-1480 (1990)).

C. Accelerated Deterioration of Inmates with AIDS

There are other significant factors that impact the cost of treatment for HIV-infected prisoners. One major influence is the accelerated rate of deterioration of AIDS inmates in prison. In New York, a 1987 study by the state's correctional association found that "the median time between diagnosis and death for prisoners with AIDS who have a history of intravenous drug use was 159 days, compared with 318 days for people with similar drug habits who are not prisoners."[153]

This accelerated deterioration demands that prisons institute high-cost, aggressive medical intervention early in the treatment of HIV-positive patients. This might include mandatory, mass blood screening on newly arrived inmates, inmates "at risk" testing, and other forms of HIV screening. However, the mandatory, mass blood screening raises constitutional issues.[154] "Despite the importance of on-request testing . . . the number of correctional systems with voluntary or on-request testing policies has actually declined slightly. This was true in State/Federal, city/county, and Canadian systems. Only about two-thirds of U.S. systems offer testing on this basis."[155]

D. Women in Prison with HIV Disease: The Forgotten Ones

While women in prison "comprise only nine percent of AIDS cases, they are the fastest growing population to be affected by HIV disease."[156] Incarcerated women with HIV also impact the medical costs for prisons because they have a higher HIV prevalence rate than the male inmates.[157]

Women inmates pose unique challenges for correctional systems:

> These women are primarily young, between the ages of 20 and 34 years old. Further, a significant number of

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153. Efrain Hernandez, Jr., *Prison Care Debated: Inmates With HIV Question Medical Treatment*, B. GLOBE, Dec. 22, 1992, at 25.

154. *See* Walker v. Sumner, 14 F.3d 1415 (9th Cir. 1994) (holding that the Nevada state prison system's mandatory HIV testing policy violated prisoners' rights under the Fourth, Eighth, and Fourteenth Amendments).

155. HAMMETT & DAUGHERTY, *supra* note 149, at 45-46.

156. HIV DISEASE IN CORRECTIONAL FACILITIES, *supra* note 151, at 25.

157. *Id.*

> women give birth to children shortly before they begin to serve prison sentences, or are pregnant and give birth during their incarceration. The Bureau of Justice Statistics reports that about 25 percent of women in correctional institutions are pregnant or post-partum.[158]

The special needs of women prisoners related to HIV disease are increasing the costs to prison's medical departments.[159] Female inmates need basic gynecological as well as other medical services. "Women in prison are in desperate need of HIV education regarding perinatal transmission and pediatric AIDS, frequent pap smears and other services sensitive to gender."[160] It is astonishing that little information is available and few research programs exist concerning female inmates afflicted with HIV disease, especially compared to the amount of information available about HIV-afflicted male prisoners. HIV-positive female inmates are identified in criminal justice statistics, but the paucity of information on the manifestations and treatment of the HIV virus in female inmates is remarkable by its absence.

Vanessa Wolfe, an HIV-positive parolee, recently stated, "Because of women's caregiver status in families, they don't go to the doctor; they place their husbands and children before themselves when it comes to medical care."[161] Wolfe contended that women come to prison with only rare medical attention in their lives, particularly if they are poor and are African-American or Hispanic.[162] Overall, according to Wolfe, "HIV positive women suffer from the same gynecological disorders as healthy women, but the difference is that the disorders can be life threatening in HIV-positive females."[163]

If female HIV inmates must contend with the same obstacles as male inmates concerning access to proper medical treatment, what distinguishes their claims from those of their male counterparts? The answer is that the "collective harm

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158. *Id.* at 26.

159. Letter from Dr. George Kaiser, Medical Director, Nevada Department of Prisons, to Susan Lundstrom (Feb. 14, 1994) (on file with author).

160. HIV DISEASE IN CORRECTIONAL FACILITIES, *supra* note 151, at 26.

161. Telephone Interview with Vanessa Wolfe, State of Nevada Parolee (Mar. 5, 1994).

162. *Id.*

163. *Id.*

experienced by women prisoners differs from that of their male counterparts. While both groups experience discrimination because of their disease, the harm that these women have experienced is, in part, a result of their gender."[164] The basic premise of our American jurisprudence is male-oriented.[165] Most case law addressing incarceration and AIDS deals with the rights of male prisoners.[166] "When women have brought their harms and claims before courts, which are constrained by legal doctrines that do more to protect the rights of men than women, courts have hesitated to intervene to end the harm."[167] Why is this so? One reason is that the courts, predominantly consisting of male judges, simply fail to realize that the physical, emotional, psychological, and sexual abuses, which ensnare women into using controlled substances and committing crimes, derive from issues not usually faced by men.[168] A 1991 article about women inmates with AIDS succinctly states the underlying issues:

> Why are these women in prison? Ironically, the harm that these women experience because they are segregated and receive inadequate medical care is, for many of them, merely the latest form of abuse that they suffer. Since childhood, many of them have suffered abuse at the hands of their fathers or

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164. Shawn Marie Boyne, *Women In Prison With AIDS: An Assault on the Constitution?*, 64 S. CAL. L. REV. 741, 750 (1991).

165. *Id.* at 794-95.

166. *Id.* (quoting Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1, 60 (1988)).

167. *Id.* at 750.

168. Women must approach the law in the same manner as they unassumingly approach their daily lives—as women:

> [T]he distinctive values women hold, the distinctive dangers from which we suffer, and the distinctive contradictions that characterize our inner lives are not reflected in legal theory because . . . [legal theory] is about actual, real life, enacted, legislated, adjudicated law, and women have, from law's inception, lacked the power to make law protect, value, or seriously regard our experience. Jurisprudence is 'masculine' because jurisprudence is about the relationship between human beings and the laws we actually have, and the laws we actually have are 'masculine' both in terms of their intended beneficiary and in authorship. . . . We will not have a genuinely ungendered jurisprudence . . . until we have legal doctrine that takes women's lives as seriously as it takes men's.

Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1, 60 (1988).

> brothers. Most were involved early in crime and became addicted to drugs. Some supported their habits through prostitution and stealing. Others were denied access to treatment because they had young children. The stories of these women are in many ways case histories of discrimination. The courts have failed to intervene because they are unable to see, understand, and empathize with that discrimination.[169]

According to a 1988 federal study on AIDS, ninety-two percent of females with AIDS contracted the disease through intravenous drug use.[170] In the federal criminal system, estimates of female prisoners having both alcohol and drug dependencies range between seventy and eighty percent.[171] Compared to these statistics, it is not surprising that the corresponding high rate of women in prison with HIV disease is compounded by drug dependencies and past abuses.[172]

The intent of this paper is not to focus on the atrocities in the criminal justice system suffered by women with HIV disease.[173] Rather, the purpose is to emphasize that these female inmates represent one of the most powerless groups of inmates in prison. In that sense, they are truly analogous to the elderly, infirm inmates. Women inmates with HIV disease—especially those with AIDS—can be "transferred to higher security institutions and housed with other prisoners who [have] committed more serious crimes solely because of

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169. Boyne, *supra* note 164, at 751.

170. THEODORE M. HAMMETT, U.S. DEP'T OF JUSTICE, AIDS IN CORRECTIONAL FACILITIES: ISSUES AND OPTIONS 26 (3d ed. 1988).

171. HIV DISEASE IN CORRECTIONAL FACILITIES, *supra* note 151, at 25.

172. Boyne, *supra* note 164, at 748, 751-52.

173. The inhumane treatments from both prison and medical staff, as well as by other inmates, endured by women prisoners, particularly in the California prison system, are some of the most shocking and revolting atrocities presently existing in this country. Furthermore, these atrocities also include covert oppression:

> The women are treated as children, and even elderly prisoners are referred to as "girls." They are made to feel even more helpless and childlike than other prisoners. The psychological oppression has worked to such an extent that few women in prison have the sense of political consciousness possessed by many of their male counterparts, nor do they have confidence in their ability to help themselves legally or socially.

Michelle Rippon & Robert A. Hassell, Comment, *Women, Prison and the Eighth Amendment*, 12 N.C. CENT. L. J. 434, 450 (1981).

[their] medical status."[174] Women inmates face chronic problems of poor medical treatment and the absence of specialists to treat their gender-related diseases, just as elderly inmates are deprived of specialists to attend their age-related infirmities.[175] Though both groups are often segregated from the rest of the prison population, women are often denied drug abuse counseling,[176] aid from outside support groups,[177] recreational activities,[178] and prison work programs.[179] This denial primarily stems not from their crimes but from the combination of their gender and their disease. Moreover, these restrictions on them occur within an environment of irrational fear and ignorance of AIDS contagion. In that sense, they are treated even worse than their elderly male counterparts.

If HIV-infected women also present low recidivist rates, the solutions recommended for use with the elderly and terminally ill inmates could be applied to them to alleviate prison overcrowding. The women would generally be ideal candidates for the ED device. Since many women in prison have children who need them, they have added incentives to comply with the ED program's restrictions on their movements. Other programs discussed for the elderly inmates—prison-managed geriatric institutions, group homes, and early conditional medical release to the inmate's family—are also appropriate measures for female inmates with HIV disease. All of these alternatives would reduce the prison population, free cells for more violent offenders, and lower costs of medical treatments.

VII. PLANNING FOR TOMORROW'S PRISONS

The challenge for tomorrow's prisons is already here today. The nation cannot delay; it cannot procrastinate. It must react now. The solutions outlined above direct the paths that must

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174. Boyne, *supra* note 164, at 742-43.

175. *Id.* at 745; *see also* Barry, *Quality of Prenatal Care for Incarcerated Women Challenged*, YOUTH L. NEWS, Nov.-Dec. 1985, at 2 (citing B. ANNO, ANALYSIS OF INMATE/PATIENT PROFILE DATA, AMA'S PROGRAM TO IMPROVE MEDICAL CARE AND HEALTH SERVICES IN JAILS (1977)).

176. Boyne, *supra* note 164, at 772.

177. *Id.*

178. *Id.* at 773 (citing Roe v. Fauver, No. 88-1225, 1988 WL 106316 (D.N.J. May 13, 1988)).

179. *Id.* at 743-44, 771.

be taken in tackling the problem of prison overcrowding. This section presents information on proposed national plans and innovative programs which attempt to incorporate some of these ideas.

A. The President's Plan

President Clinton's proposed $22 billion dollar "strong arm" crime bill aims at releasing more money for building prisons, putting more policemen on the streets, and sentencing more violent offenders to prison.[180] These expensive goals, however, will not solve the overpopulation problems in the prisons and jails. Indeed, the plan may very well exacerbate the overcrowding problem. Across the country, the nation is experiencing a prison meltdown. Prisons must be run more like a business instead of a place to put "three strikes and you're out" criminals for life without chance of parole. The Attorney General of the United States, Janet Reno, recently stated, "[y]ou don't want to be running a geriatric ward at age 75 or 80 for people who are no longer dangerous."[181] American taxpayers simply cannot afford it. This paper has addressed the significant problems presented by overcrowding and how age, illness, and recidivism rates can be analyzed to determine which prisoners should be released to alleviate prison overcrowding.

B. Who is Responsible?

The problems caused by the massive prison overcrowding, compounded by the enormous growth in the prison population as a whole, require immediate reaction, innovation, compassion and strong leadership by prison bureaucracy. Yet prison administrators do not have the sole responsibility for finding and implementing solutions. Answers to prison overcrowding and medical challenges require a coordinated response originating from an integrated body composed of the state's governor, social services agencies, military leaders, prison staffs, legal experts, medical reformers, and the general public.

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180. Richard Lacayo, *Lock 'Em Up!*, TIME, Feb. 7, 1994, at 53.

181. *Reno Debates Fate of Aged Prison Inmates*, THE DAILY UNIVERSE [student newspaper of Brigham Young University], Feb. 11, 1994, at 2.

This broad-based approach to the problem must be used because the solutions are not unique to any particular public sector. Possible solutions involve the use of hospitals on military installations scheduled for closure; the staffing of a mixture of social service, medical, and security personnel within a prison-managed nursing home or a halfway house setting, in accordance with local laws; and the medical release of inmates to their families or to a nursing home. Medical experts will be required to make difficult decisions concerning which inmates fit the category either for release or for confinement in a specialized prison facility. Consideration of the public's attitude and safety concerns are paramount to bringing about radical changes in the current notions regarding incarceration for criminals, particularly for elderly inmates serving life-without-parole sentences.

The government currently struggles to develop a national medical reform plan. If the nation adopts a new health care system that assures each person access to medical care, prison officials would be required to insure that every prisoner—regardless of age, crime, or gender—receive appropriate care. As a result, some of the major financial obstacles faced by prisons in implementing early release of elderly felons and terminally ill inmates may be alleviated.

Both at the local and federal government levels, time is crucial. The nation[182] must plunge into the deep water of prison overcrowding and medical and operating cost problems before it floods us, creating one of the worst social upheavals in decades. A blueprint for the future of prisons must be developed for managing crime before a wedge is struck sharply into the socio-economic basis for prison reform from which this nation may not recover.

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182. The adage that "war is too important to leave it to the generals" I equate to the battle against our prison overcrowding and associated problems as described in this paper. These issue resolutions beg not only for the pearls of wisdom from experts across the criminal justice and social service spectrum but also from the "nuts and bolts" input of ordinary citizens willing to participate in the joint venture to overcome the problems. The "we" means the people from all occupations, skills, and beliefs who would be willing to participate in a group mission to help each state solve its individual prison population challenges.

VIII. CONCLUSION

America cannot "jail" its way out of the national crime crisis and prison budget busting. Our country's attempts to pay its way through this crisis by building more prisons, by increasing security personnel, and by mandating specific prison terms do nothing but increase the costs of the prisons. The amount of crime and escalating violence are persistently growing evils. The "War on Drugs" has yielded to "Lock'em Up Fever," but crime still grips our country, insulting its professed values and causing agonies to its victims.

The American public demands action on crime. Politicians cannot ignore the public's drumbeat of reform. It is time to act. The solution, however, cannot be limited to packing more criminals into prisons while many dangerous inmates are silently slipped out the back door to make room for the newcomers.

One of the major solutions to prison overcrowding is to grant early pardons to elderly, low-risk inmates, and inmates suffering from terminal diseases. These groups of inmates cause higher prison costs and will continue to do so unless this nation makes changes in its correctional systems. New alternative measures to incarceration, such as electronic home detection and both private and prison-run geriatric homes, must be created. All possible alternatives to prison incarceration must be considered, and each inmate's eligibility must be reviewed on a case-by-case basis. Low-risk inmates who pose little threat to society and who are either elderly or terminally ill must be considered for early release.

The American public wants criminals to "pay" for their crimes through prison incarceration. The public does not like to hear about a prisoner's early release. Yet, the public does understand the necessity to make room in our prisons for the predominant group of young, violent offenders, and the public also understands and dislikes the enormous taxes required for prison construction costs. If options other than incarceration are successful for the elderly inmates, the public may be more receptive to an expansion of proposed releases, particularly for inmates with terminal illnesses, regardless of age. Programs like "POPS" can be tailored to the risk assessment characteristics of any state's prison population problem. However, the programs must be innovative; they must achieve actual and real financial benefits to the state and its people.

Otherwise, new proposals are perceived as further ineffective government programming.

Inmates, too, have their stories to tell. Sherri, terminally ill from the ravages of AIDS, agonizes and waits, and waits, for a favorable decision from the state pardon's board, which holds biannual meetings. She hopes for the miracle of early release. She is not dangerous; she is not a violent criminal. Then there is A.C., barely able to function from the loss of one kidney and the expected loss of the other. He takes pills—lots of pills—just to live through each day. He does nothing much, except watch television. He is not dangerous; he is just a fraudulent check writer and an extremely ill man. These low-risk inmates could easily be released under any of the proposed methods outlined in this paper. Their release would make room for the violent criminals that must not be allowed on the streets.

People solve problems; ideas alone do not. Experimental programs like POPS have been successful in reducing prison populations without endangering society. The ideas are not complex, although implementing them requires precise coordination among several agencies.

What is missing in our criminal justice system is leadership. The nation needs a person—or group of people—with visions of excellence, of creativity, of power to motivate the right people to do the right thing about our prison crisis and implement the right solutions. After all, one individual's idea recently activated nationwide programs of trading handguns for cash or other highly treasured items.[183] The President of the United States cannot do it alone. Congress cannot do it alone. The Supreme Court cannot enforce laws that have not been enacted. Yet, America does have individuals like Professor Jonathan Turley, individuals who are very special men and women willing to tackle the hard issues and who are forceful and dedicated enough to follow through to the finish line. Leaders must come forth and be heard, supported, and followed in order to meet the nation's goals of safety for society and reduction of prison overcrowding.

Susan Lundstrom

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183. *See, e.g.*, Carrie Borzillo, *TicketMaster Offers to Trade Concert Seats for Firearms*, BILLBOARD, Nov. 20, 1993, at 10; Karen Pallarito, *Hospitals Taking Aim to Curb Gun Violence*, MOD. HEALTHCARE, Feb. 21, 1994, at 26.